

Salary Continuance Plan - Employer Statement

Date Received: 10/10/01

Laura Patrick

Employee Name

025-52-1378

Social Security Number

What type of Leave is the employee currently on:

☐ Standard Leave

☒ Family Medical Leave

☐ Intermittent Leave

Does the employee have any available sick pay? ☐ Yes ☒ No

If yes, how many hours and for which days?                     

Will the employee be using any vacation pay for the 3-day waiting period or beyond?

☐ Yes ☒ No

If yes, how many hours and for which days?                     

Have you notified Payroll of these hours? ☒ Yes ☐ No

Will the employee be working any hours during this leave? ☐ Yes ☒ No

If yes, how many hours and for which days?                     

Employee's date of hire: 8-1-94

Adjusted date of hire (if any):                     

Percentage of basic weekly salary payable:

☐ 0 to 5 years of service (67%)

☒ 5 to 10 years of service (75%)

☐ 10+ years of service (80%)

State Disability: ☐ CA ☐ NJ ☐ NY

Is the employer seeking reimbursement for State Disability? ☐ Yes ☒ No

**\*\*You must attach a copy of the State Disability Application\*\***

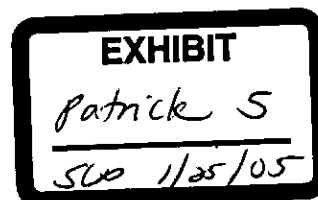
Rachel Greene

Employer Representative

10/10/01

Date

Form last updated: 10-23-00



New Form 5/25/01

## Application for Salary Continuance—Salaried Employees

Name: LAURA E. PATRICKWork Location (Company name): JANSSONJob Title: DESIGN DEVELOPER Social Security Number: 025 521378Estimated Dates of Leave: 10-15 THRU 11-26

Reason for Leave: (check one)

1. Pregnancy/Childbirth ☐2. Illness ☒3. Injury ☐When did you become unable to work? 10-15-2001What was your last day worked? 10-12-2001If requested leave is for reasons 2 or 3 above, please provide a brief description of the illness or injury: INFERTILITY CYCLE WITH ADDITIONAL SURGICAL PROCEDURESALONG WITH DAILY LABWORK, EXAMS AND ULTRASOUNDSDid the injury or illness result from employment? Yes ☐ No ☒If yes, are you receiving workers' compensation? Yes ☐ No ☐Are you receiving any other form of disability compensation from your employer? Yes ☐ No ☒Do you have sick days to use for any portion of your leave? Yes ☐ No ☒

If yes, how many days? \_\_\_\_\_ (This information will be verified by the Payroll Dept)

Do you wish to use vacation/personal days for any portion of the 3-day waiting period?

If yes, how many days? Personal \_\_\_\_\_ Vacation \_\_\_\_\_

Do you plan to work part time during any portion of your leave? If yes, please describe your anticipated schedule: \_\_\_\_\_

**EMPLOYEE VERIFICATION:** I certify that the information on this application is true and correct to the best of my knowledge. I acknowledge that I will be required to submit a physician's certification prior to becoming qualified for salary continuation benefits, and authorize my physician, insurer or hospital to disclose any information necessary regarding the condition requiring my leave.

Date: 10-10-2001 Signature of Employee: [Signature]Home telephone number of employee: 781-639-0902

Please return this form to your Supervisor

JAN 000042

New Form 5/25/01

**Physician's Certification - Salary Continuance Plan**

The patient is responsible for the completion of this form without expense to the Company.

Patient/Employee's Name: LAURA PATRICKSocial Security Number: 025-52-1078

If leave is due to maternity/childbirth:

Type of Delivery: \_\_\_\_\_

Date of Delivery: \_\_\_\_\_

Please state the period during which patient will be unable to work: \_\_\_\_\_  
\_\_\_\_\_

If leave is due to injury or illness:

1. Is the patient presently unable to work or do you anticipate the patient will be unable to work due to injury or illness? YES
2. Date patient became unable to work: \_\_\_\_\_
3. Please describe the medical facts which support your certification: Patient will need to be available for daily blood work and ultrasounds.
4. State the approximate date the condition commenced and the probable duration of the condition (and also the probable duration of the patient's incapacity, if different): Patient will be unable to work from Oct 15, 2001 - Nov 24, 2001
5. If additional treatments will be required for the condition, please describe such treatments: \_\_\_\_\_  
\_\_\_\_\_

Printed or typed name of Health Care Provider: Mitchell S. Pein  
 Type of Practice: Reproductive medicine  
 Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: 1 Hutchinson Drive DANVERS MA 01923  
 Telephone Number: 978-777-1070

**EMPLOYEE PLEASE NOTE:** If the length of disability exceeds the reasonable length of time for the diagnosis given, we reserve the right to require another doctor's opinion. The doctor's statement must be received within 30 days from the date the condition necessitating the leave began, and if leave is requested for any reason other than maternity/childbirth, an updated doctor's statement is needed every 30 days.

Please mail completed form to:  
 Taylor Corporation  
 Benefits Department Attn: Cindy Ross  
 1725 Roe Crest Drive  
 North Mankato, MN 56003

JAN 000043



THE NORTH SHORE  
MEDICAL CENTER

October 5, 2001

Jansson  
411 Waverly Oaks Rd  
Waltham, MA 02154  
Attn: Human Resources Dept.

**Mitchell Rein, MD**  
*Chief, Department of  
Obstetrics/Gynecology  
Director of Women's Services*

*Women's Health Center  
of the North Shore  
1 Hutchinson Drive  
Danvers, MA 01923  
Tel: 978 777-1070  
Fax: 978 774-9635*

*Salem Hospital  
Medical Office Building, Suite 316  
79 Highland Avenue  
Salem, MA 01970  
Tel: 978 744-7668  
Fax: 978 744-8126*

To Whom It May Concern:

Laura Patrick has been under my care for infertility since September of 1999. Due to ongoing medical complications, her fertility treatment to date has been unsuccessful. The next fertility cycle will be more demanding on her physically due to an additional and more complicated surgical procedure.

Infertility can take a significant physical, emotional, and economic toll on those struggling to become pregnant. It is my recommendation that Laura take a medical leave for her next 6-week cycle, which begins on October 15, 2001.

Should you have any questions regarding this letter, please feel free to contact me at (978) 777-1070.

Sincerely,

  
Mitchell S. Rein, MD

MSR:gad